

Department of Veterans Affairs

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eligible and dental treatment authorized on a one-time basis without rating action if:

(a) The examination to determine the need for dental care has been accomplished within the specified time limit after date of discharge or release unless delayed through no fault of the veteran, and sound dental judgment warrants a conclusion the condition originated in or was aggravated during service and the condition existed at the time of discharge or release from active service, and

(Authority: 38 U.S.C. 1712)

(b) The treatment will not involve replacement of a missing tooth noted at the time of Department of Veterans Affairs examination except:

(1) In conjunction with authorized extraction replacement, or

(2) When a determination can be made on the basis of sound professional judgment that a tooth was extracted or lost on active duty.

(c) Individuals whose entire tour of duty consisted of active or inactive duty for training shall not be eligible for treatment under this section.

[37 FR 6847, Apr. 5, 1972, as amended at 48 FR 16682, Apr. 19, 1983. Redesignated and amended at 61 FR 21966, 21968, May 13, 1996]

§ 17.163 Posthospital outpatient dental treatment.

The Chief, Dental Service may authorize outpatient dental care which is reasonably necessary to complete treatment of a nonservice-connected dental condition which was begun while the veteran was receiving Department of Veterans Affairs authorized hospital care.

(Authority: 38 U.S.C. 1712(b)(5))

[45 FR 6939, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.164 Patient responsibility in making and keeping dental appointments.

Any veteran eligible for dental treatment on a one-time completion basis only and who has not received such treatment within 3 years after filing the application shall be presumed to

have abandoned the claim for dental treatment.

[45 FR 6939, Jan. 31, 1980. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.165 Emergency outpatient dental treatment.

When outpatient emergency dental care is provided, as a humanitarian service, to individuals who have no established eligibility for outpatient dental care, the treatment will be restricted to the alleviation of pain or extreme discomfort, or the remediation of a dental condition which is determined to be endangering life or health. The provision of emergency treatment to persons found ineligible for dental care will not entitle the applicant to further dental treatment. Individuals provided emergency dental care who are found to be ineligible for such care will be billed.

(Authority: 38 U.S.C. 501)

[50 FR 14704, Apr. 15, 1985; 50 FR 21604, May 28, 1985. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.166 Dental services for hospital or nursing home patients and domiciled members.

Persons receiving hospital, nursing home, or domiciliary care pursuant to the provisions of §§ 17.46 and 17.47, will be furnished such dental services as are professionally determined necessary to the patients' or members' overall hospital, nursing home, or domiciliary care.

[30 FR 1790, Feb. 9, 1965. Redesignated at 61 FR 21966, May 13, 1996]

§ 17.169 VA Dental Insurance Program for veterans and survivors and dependents of veterans (VADIP).

(a) *General.* (1) The VA Dental Insurance Program (VADIP) provides premium-based dental insurance coverage through which individuals eligible under paragraph (b) of this section may choose to obtain dental insurance from a participating insurer. Enrollment in VADIP does not affect the insured's eligibility for outpatient dental services and treatment, and related dental appliances, under 38 U.S.C. 1712.

(2) The following definitions apply to this section:

Insured means an individual, identified in paragraph (b) of this section, who has enrolled in an insurance plan through VADIP.

Participating insurer means an insurance company that has contracted with VA to offer a premium-based dental insurance plan to veterans, survivors, and dependents through VADIP. There may be more than one participating insurer.

(b) *Covered veterans and survivors and dependents.* A participating insurer must offer coverage to the following persons:

(1) Any veteran who is enrolled under 38 U.S.C. 1705 in accordance with 38 CFR 17.36.

(2) Any survivor or dependent of a veteran who is eligible for medical care under 38 U.S.C. 1781 and 38 CFR 17.271.

(c) *Premiums, coverage, and selection of participating insurer.* (1) *Premiums.* Premiums and copayments will be paid by the insured in accordance with the terms of the insurance plan. Premiums and copayments will be determined by VA through the contracting process, and will be adjusted on an annual basis. The participating insurer will notify all insureds in writing of the amount and effective date of such adjustment.

(2) *Benefits.* Participating insurers must offer, at a minimum, coverage for the following dental care and services:

(i) *Diagnostic services.*

(A) Clinical oral examinations.

(B) Radiographs and diagnostic imaging.

(C) Tests and laboratory examinations.

(ii) *Preventive services.*

(A) Dental prophylaxis.

(B) Topical fluoride treatment (office procedure).

(C) Sealants.

(D) Space maintenance.

(iii) *Restorative services.*

(A) Amalgam restorations.

(B) Resin-based composite restorations.

(iv) *Endodontic services.*

(A) Pulp capping.

(B) Pulpotomy and pulpectomy.

(C) Root canal therapy.

(D) Apexification and recalcification procedures.

(E) Apicoectomy and periradicular services.

(v) *Periodontic services.*

(A) Surgical services.

(B) Periodontal services.

(vi) *Oral surgery.*

(A) Extractions.

(B) Surgical extractions.

(C) Alveoloplasty.

(D) Biopsy.

(vii) *Other services.*

(A) Palliative (emergency) treatment of dental pain.

(B) Therapeutic drug injection.

(C) Other drugs and/or medications.

(D) Treatment of postsurgical complications.

(E) Crowns.

(F) Bridges.

(G) Dentures.

(3) *Selection of participating insurer.* VA will use the Federal competitive contracting process to select a participating insurer, and the insurer will be responsible for the administration of VADIP.

(d) *Enrollment.* (1) VA, in connection with the participating insurer, will market VADIP through existing VA communication channels to notify all eligible persons of their right to voluntarily enroll in VADIP. The participating insurer will prescribe all further enrollment procedures, and VA will be responsible for confirming that a person is eligible under paragraph (b) of this section.

(2) The initial period of enrollment will be for a period of 12 calendar months, followed by month-to-month enrollment, subject to paragraph (e)(5) of this section, as long as the insured remains eligible for coverage under paragraph (b) of this section and chooses to continue enrollment, so long as VA continues to authorize VADIP.

(3) The participating insurer will agree to continue to provide coverage to an insured who ceases to be eligible under paragraphs (b)(1) through (2) of this section for at least 30 calendar days after eligibility ceased. The insured must pay any premiums due during this 30-day period. This 30-day coverage does not apply to an insured who is disenrolled under paragraph (e) of this section.

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(e) *Disenrollment.* (1) Insureds may be involuntarily disenrolled at any time for failure to make premium payments.

(2) Insureds must be permitted to voluntarily disenroll, and will not be required to continue to pay any copayments or premiums, under any of the following circumstances:

(i) For any reason, during the first 30 days that the beneficiary is covered by the plan, if no claims for dental services or benefits were filed by the insured.

(ii) If the insured relocates to an area outside the jurisdiction of the plan that prevents the use of the benefits under the plan.

(iii) If the insured is prevented by serious medical condition from being able to obtain benefits under the plan.

(iv) If the insured would suffer severe financial hardship by continuing in VADIP.

(v) For any reason during the month-to-month coverage period, after the initial 12-month enrollment period.

(3) All insured requests for voluntary disenrollment must be submitted to the insurer for determination of whether the insured qualifies for disenrollment under the criteria in paragraphs (e)(2)(i) through (v) of this section. Requests for disenrollment due to a serious medical condition or financial hardship must include submission of written documentation that verifies the existence of a serious medical condition or financial hardship. The written documentation submitted to the insurer must show that circumstances leading to a serious medical condition or financial hardship originated after the effective date coverage began, and will prevent the insured from maintaining the insurance benefits.

(4) If the participating insurer denies a request for voluntary disenrollment because the insured does not meet any criterion under paragraphs (e)(2)(i) through (v) of this section, the participating insurer must issue a written decision and notify the insured of the basis for the denial and how to appeal. The participating insurer will establish the form of such appeals whether orally, in writing, or both. The decision and notification of appellate rights must be issued to the insured no later than 30 days after the request for vol-

untary disenrollment is received by the participating insurer. The appeal will be decided and that decision issued in writing to the insured no later than 30 days after the appeal is received by the participating insurer. An insurer's decision of an appeal is final.

(5) Month-to-month enrollment, as described in paragraph (d)(2) of this section, may be subject to conditions in insurance contracts, whereby upon voluntarily disenrolling, an enrollee may be prevented from re-enrolling for a certain period of time as specified in the insurance contract.

(f) Other appeals procedures. Participating insurers will establish and be responsible for determination and appeal procedures for all issues other than voluntary disenrollment.

(g) *Limited preemption of State and local law.* To achieve important Federal interests, including but not limited to the assurance of the uniform delivery of benefits under VADIP and to ensure the operation of VADIP plans at the lowest possible cost to VADIP enrollees, paragraphs (b), (c)(1), (c)(2), (d), and (e)(2) through (5) of this section preempt conflicting State and local laws, including laws relating to the business of insurance. Any State or local law, or regulation pursuant to such law, is without any force or effect on, and State or local governments have no legal authority to enforce them in relation to, the paragraphs referenced in this paragraph or decisions made by VA or a participating insurer under these paragraphs.

(Authority: Sec. 510, Pub. L. 111-163)

(The Office of Management and Budget has approved the information collection requirement in this section under control number 2900-0789.)

[78 FR 32130, May 29, 2013, as amended at 78 FR 62443, Oct. 22, 2013]

AUTOPSIES

§ 17.170 Autopsies.

(a) *General.* (1) Except as otherwise provided in this section, the Director of a VA facility may order an autopsy on a decedent who died while undergoing VA care authorized by § 17.38 or § 17.52, if the Director determines that an autopsy is required for VA purposes for the following reasons: